TRANSACTION DESCRIPTIONS

General Rule. Except as otherwise provided in this part, if a covered entity conducts with another covered entity (or within the same covered entity) using electronic media . . . the covered entity must conduct as a standard transaction. Additionally, some implementation guides (*IG*) provide additional specificity.

1 **Claim** - **837** - request to obtain payment or report encounter

FROM a provider TO a health plan
IG: Supports submission from a provider, provider's agent, or a payer in an encounter reporting situation, flows to a destination payer

2 **Eligibility** - **270/271**- inquiry regarding enrollee eligibility, coverage, or benefits

FROM a provider TO a health plan, OR
FROM one health plan TO another health plan
IG: inquiry typically from a provider or another insurer or payer. Information source is typically the insurer, or payer, or in managed care may be a PCP or gateway provider.

3 **Referral Certification and Authorization** - **278-** Request or response to a request for review and authorization to obtain health care or referral to another health care provider

No specification, see general rule. Check the implementation guide for entities supported
IG: Accommodates the exchange of information between providers and review entities, including admissions certification review, referral review, health care services or extend certification review or appeal, and responses.

4 **Claim Status** – **276/277**- Inquiry to determine the status of a health care claim and the response

No specification, see general rule. Check the implementation guide for entities supported
IG: supports entities who request the status of health care claims and entities who respond to requests. Inquirers include: providers, professional groups, employers, supplemental payers, adjudication processors. Responders include: insurance co., TPA, service corporations, gov. agencies and their contractors, plan purchasers, others who process claims. Other business partners affiliated: billing services, consulting services, vendors of systems, VANs, and ACHs.

5 **Enrollment and Disenrollment** – **834**- transmission of subscriber enrollment information to establish or terminate insurance coverage

No FROM specification, must be TO a health plan.
IG: Supports transfer of enrollment and maintenance info. from the sponsor of insurance coverage, benefit, or policy to a payer. Sponsor – is the party that ultimately pays for the coverage, benefit, or product. Can be employer, union, government agency, association, or insurance agency. Payer is the party that pays claims and/or administers the insurance benefits. Payer can be insurance company, HMO, PPO, government agency, or other contracted organization.

6 **Health Care payment and remittance advise** – **835**

transmission FROM a health plan TO a provider's financial institution of payment, transfer of funds, or payment processing information , OR transmission FROM a health plan TO a provider of explanation of benefits or remittance advice
IG: Supports those who send and/or receive electronic remittance advice (RA) and or payments. Receivers include providers such as hospitals, nursing homes, labs, physicians, allied professional groups. Senders include ins. Co., TPA, service corps, gov. agencies and their contractors, plan purchasers, other entities that process health care RA.

7 **Premium payments transaction** – **820-** payment, transfer of funds, detailed remittance information about individual for whom premiums being paid, payment processing information to transmit premium payments

FROM an entity arranging for health care or providing health care coverage payments for an individual TO a health plan
IG: Supports reporting of payroll deducted and other group premiums. Designed for employer or agency performing payroll processing, government agency paying health care premiums, or employer paying group premiums sent to an insurance company, health care organization, or gov. agency. Can be sent to bank to move money only, move money and give remittance info., or sent to directly to payee to give remittance info.

8 **Coordination of Benefits** – **837**- transmission of claims(including encounter information) or payment information for purpose of determining relative payment responsibilities or reporting encounter information

FROM any entity TO a health plan
IG: Two models of COB. Provider to payer and back to provider; or Provider to payer, to secondary payer. Most extensive payer to payer COB are Medicare to Medicaid/Medicare secondary payers.

COMMENTS

Corporate Boundary Issue
Health Plan Requirements
Transaction Specifics and Exclusions
Transaction Examples
Services Referenced
**Italics are added text.*

Corporate Boundary Issue -
50317(a) Thus, the fundamental policy is that covered entities must use a standard transaction when transmitting a transaction covered by this part with another covered entity (or within the same covered entity) electronically, regardless of whether the transmission is inside or outside the entity.

Health Plan Requirements -
50314(b) With respect to health plans, a health plan is required to have the capacity to accept and/or send (either by itself or by hiring a health care clearinghouse to accept and/or send on its behalf) a standard transaction that it otherwise conducts but does not currently support electronically.

50338(b) (Comment and response) – One commenter stated we need to make it clear that if a State Health Agency does not participate in the enrollment functions, it is not required to use the standard. Health plans, including State health agencies, are not required to conduct a standard transaction based solely on the fact that it is a standard transaction.

50336(c) A health plan may not refuse to process a transaction simply because it is a standard transaction. Whether a health plan may refuse to process a transaction on other grounds may depend upon the particular business agreements the health plans has with the sender. . . Use of a standard transaction does not create a relationship or liability that does not otherwise exist. A health plan would not be required by these rules to respond to such a request from a health care provider with whom it does not have a business arrangement.

50337(a) All health plans, including state Medicaid plans, must have the capability to accept, process, and send the 276/277 (claim status) transactions.

50336(b) Under this rule, health plans are only required to accept COB transactions from other entities, including those that are not covered entities, with which they have trading partner agreements to conduct COB.

Transaction Specifics and Exclusions –

50336(b) - A COB transmission between a health care provider and a payer that is not a health plan would not be subject to the requirements of this rule; nor would the transmission of a COB transaction from a health plan to another payer that is not another health plan.

50338(b) Monthly capitation claims from a managed care organization to a State Medicaid Agency do not fall within the rules we have established for transactions between health plans. The transaction does not meet the definition of a health care

claim or equivalent encounter information transaction. *(Note: Capitation claims are not the same as the reporting of encounter information collected from the providers in a health plan and sent by that health plan to another health plan.)*

50338(b) (Comment and response) …An interface between a State and the State's processing associate, specifically for data entry, should not be required to be in a standard format. We agree. In this scenario, data entry does not fall within any of the definitions for standard transactions.

50338(c) A State Medicaid program is acting as a sponsor and is excepted from the HIPAA standard requirements only when purchasing coverage for its own employees. The State Medicaid program is not acting as a sponsor when enrolling Medicaid recipients in contracted managed care health plans, and thus is not excepted from the law. *(Note however, that other transactions may be implicated like 834 with MCHP).*

50338(c) The transmission between a State Medicaid Agency and HCFA for the purpose of buy-in is outside of the scope of this requirement. State buy-in, the process by which State Medicaid programs pay only the Medicare premium for certain categories of dually eligible individuals is essentially a Medicaid subsidy, required under Federal law, of Medicare insurance. This transaction is neither an enrollment and disenrollment in a health plan nor a health plan premium transaction.

50337 (b) We recognize that entities that are not covered under HIPAA, such as sponsors of health plans, including employee welfare benefit plans, are not required to use the HIPAA standards to perform EDI with health plans. *(Note – some sponsors are also covered health plans – insurers and government agencies)*

50335(a) Although these standard transactions (835 and 820) allow transmission of one or both parts through a financial institution, they do not require both parts to be sent to the financial institution and the financial institution is not required by this regulation to accept or forward such transactions. Health plans may continue to use ACH transaction alone to authorize the transfer of funds (electronic funds transfer) when such transfer is not part of paying a health care premium or a health care claim for an individual, because such a transaction would not be a transaction covered by this part.

50334(c) (Comment and response) A few state Medicaid agencies requested that they be permitted to use the 835 format rather than the 820 to pay premiums to managed care companies under contract to provide care to Medicaid beneficiaries. Although the 835 can accommodate claims and capitation payments to health care providers, including managed care companies, the payments described in these comments are considered health plan premium payments, rather than payment for direct patient care... All health plan premium payments must be transmitted with the 820 standard . . .

50335(a) We clarify that 835 will be sent from a health plan to health care providers and/or clearinghouses. W are not regulating the explanation of benefits (EOB) that health plans send to their subscribers.

50335(a) A health plan can choose to continue to send paper remittance advise notices to health care providers that are issued 835 transactions. However, all information in the paper notice that could have been expressed in the 835 must be included in the 835. . . Health plans need to work with DSMO's to modify standard if needed.

Transaction Examples - 50317/50318

Example 1: Corporation K operates a health plan that is a covered entity under these rules. Corporation K owns a hospital which provides care to patients with coverage under Corporation K's health plan and also provides care to patients with coverage under other health plans. Corporate rules require the hospital to send encounter information electronically to Corporation K identifying the patients covered by the corporate plan and served by the hospital.

(A) Must the transmission of encounter data comply with the standards? Both the health plan and the hospital are covered entities. The hospital is a covered entity because it is conducting covered transactions electronically in compliance with its corporate rules. The electronic submission of encounter data satisfies the definition of the health care claims or equivalent encounter information transaction designated as a standard transaction (see Sec. 162.1101(b)). Therefore, the submission of this encounter data therefore must be a standard transaction.

(B) Must the payments and remittance advices sent from Corporation K's health plan to the hospital be conducted as standard transactions? Corporation K's health plan is covered by the definition of ``health plan,'' the hospital is a covered entity, and the transmission of health care payments and remittance advices is within the scope of the designated transactions (see Sec. 162.1601). The health care payments and remittance advices must be sent as standard transactions.

Example 2: A large multi-state employer provides health benefits on a self-insured basis, thereby establishing a health plan. The health plan contracts with insurance companies in seven states to function as third party administrators to process its employees' health claims in each of those states. The employer's health plan contracts with a data service company to hold the health eligibility information on all its employees. Each of the insurance companies sends eligibility inquiries to the data service company to verify the eligibility of specific employees upon receipt of claims for services provided to those employees or their dependents.

(A) Are these eligibility inquiries activities that must be conducted as standard transactions? In this case, each insurance company is not a covered entity in its own right because it is functioning as a third party administrator, which is not a covered entity. However, as a third party administrator (TPA), it is the business associate of a covered entity (the health plan) performing a function for that entity; therefore, assuming that the covered entity is in compliance, the TPA would be required to follow the same rules that are applicable to the covered entity if the covered entity performed the functions itself. The definition for the eligibility for a health plan transaction is an inquiry from a health care provider to a health plan, or from one health plan to another health plan, to determine the eligibility, coverage, or benefits associated with a health plan for a subscriber. In this case, the inquiry is from one business associate of that health plan to another business associate of that same health plan. Therefore, the inquiry does not meet the definition of an eligibility for a health plan transaction, and is not required to be conducted as a standard transaction.

(B) Is an electronic eligibility inquiry from a health care provider to the data service company, to determine whether an employee-patient may receive a particular service, required to be a standard transaction? The health care provider is a covered entity, because it conducts covered electronic transactions. The data service company is the business associate of the employer health plan performing a plan function. Therefore, the activity meets the definition of the eligibility for a health plan transaction, and both the inquiry and the response must be standard transactions.

Example 3: A pharmacy (a health care provider) contracts with a pharmacy benefits manager (PBM) to forward its claims electronically to health plan Z. Under the contract, the PBM also receives health care payment and remittance advice from health plan Z and forwards them to the pharmacy.

(A) Must the submission of claims be standard transactions? The pharmacy is a covered entity electronically submitting, to covered entity health plan Z, health care claims or equivalent encounter information, which are designated transactions (see Sec. 162.1101), through a business associate, the PBM. The claims must be submitted as standard transactions.

(B) Must the explanation of benefits and remittance advice information be sent as a standard transaction? Health plan Z and the health care provider are covered entities conducting one of the designated transactions (see Sec. 162.1601). This transaction, therefore, must be conducted as a standard transaction.

Example 4: A State Medicaid plan enters into a contract with a managed care organization (MCO) to provide services to Medicaid recipients. That organization in turn contracts with different health care providers to render the services.

(A) When a health care provider submits a claim or encounter information electronically to the MCO, is this activity required to be a standard transaction? The entity submitting the information is a health care provider, covered by this rule, and the MCO meets our definition of health plan. The activity is a health care claims or equivalent encounter information transaction designated in this regulation. The transaction must be a standard transaction.

(B) The managed care organization then submits a bill to the State Medicaid agency for payment for all the care given to all the persons covered by that MCO for that month under a capitation agreement. Is this a standard transaction? The MCO is a health plan under the definition of ``health plan'' in Sec. 160.103. The State Medicaid agency is also a covered entity as a health plan. The activity, however, does not meet the definition of a health care claims or equivalent encounter information transaction. It does not need to be a standard transaction.

However, note that the health plan premium payment transaction from the State Medicaid agency to the health plan would have to be conducted as a standard transaction because the State Medicaid agency is a covered entity sending the transaction to another covered entity (the health plan), and the transaction meets the definition of health plan premium payment.

Services Referenced

50315(c) We agree with commenters that case management is a health care service since it is directly related to the health of an individual and is furnished by health care providers. Case management will, therefore, be subject to the standards.

50316(a) Services that are not health care services or supplies under this definition are not required to be claimed using the standard transactions. Thus, claims for non-emergency transportation or carpentry services for housing modifications, if submitted electronically, would not be required to be conducted as standard transactions. As noted above, the standards do support such claims and a health plan may choose to require its atypical service providers to use the standards for its own business purposes.

50316(a) Those atypical services that meet the definition of health care, however, must be billed using the standard if they are submitted electronically. If there are no specific codes for billing a particular service (for example, there is not yet an approved code set

for billing for alternative therapies), or if the standard transactions do not readily support a particular method of presenting an atypical service (for example, roster billing for providing immunizations for an entire school or nursing facility), the health care service providers are urged to work with the appropriate Designated Standard Maintenance Organizations (DSMOs) to develop modifications to the standard and implementation specifications.

50316(a) First, Congress explicitly included the Medicaid programs as health plans that are subject to the administrative simplification standards. Second, these waiver programs commonly pay for a mix of health care and non-health care services. State Medicaid agencies with home and community based waivers are not exempt from these standards for transactions relating to health care services or supplies.

50325(b) In addition, the proposed rule did not itemize the types of services included in other health care services. These other health care services include the ancillary services, radiology and laboratory which are mentioned in the comment, as well as other medical diagnostic procedures, physical and occupational therapy, hearing and vision services, and transportation services including ambulance. Similarly, other substances, equipment, supplies, or other items used in health care services includes medical supplies, orthotic and prosthetic devices, and durable medical equipment.

50326(a) Some commenters indicated that the[the code sets proposed] lacked sufficient specificity to code data elements in several areas: functional status and other data elements necessary for studying persons with mental illness; behavioral health; chronic conditions and functional assessments covered by long term care insurance; and mental health services. We agree the code sets proposed as HIPAA standards may not cover functional status, mental and behavioral health, chronic conditions, and mental health services to the extent required by the legitimate business needs of some health care providers and health plans. We are unaware of any viable alternative code sets which cover these areas more completely.